Patients can now complete and submit release form electronically

Scan this QR code with the camera from your phone or tablet

Patient Name:	Date of Birth:	Social Security No.(optional):
Provider's Name: WVU Health System	Provider's Address: PO Box 8049 Morgantown, WV 26506	Provider's Phone:304-598-4110 Provider's Fax:304-598-4129

Recipient's Name:

Recipient's Address:

City State Zip

Recipient's Phone and Fax:

Phone No. Fax No.

This authorization will expire in 1 year (365 Days) unless otherwise specified:

Description of information to be used or disclosed

	Date:		Date:		Date:
After Visit Summary		EKG/ Rhthym Strips		Office Visits	
Ambulance Run Sheet		Emergency Room		Operative/ Procedure	
Cancer Center		History & Physical		Pathology	
Cardiac Cath Report		Immunizations		Physical Therapy	
Consult		Labs		Radiology Report	
Discharge Summary		Nurse's Notes		Radiology Image	

Other (please specify):

I acknowledge, and herby consent to such, that the released information may contain pregnancy, alcohol, drug abuse, psychiatric, HIV or Aids information. _____ (initials)

I understand that:

***I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations,information described above may be re-disclosed to other individuals or institutions and no longer protected by these regulations**

***I understand that I may inspect and receive a copy of this authorization.**

***I understand WVU Health System will not refuse to treat me simply because I do not sign this authorization.**

***I understand that I may revoke this authorization at any time in writing except where action has already been taken in reliance upon this authorization.**

Written revocation may be sent to PO Box 8049, Morgantown, WV 26506.

By revoking this authorization:

Decision to revoke the authorization does not apply to any release of information that may have taken place prior to the revocation request.

Decision to revoke the authorization may result in your insurance company to not be able to pay for medical care and you may be liable to payment of claims.

I have read the above and authorize the disclosure of the protected health information as stated.
Pregnancy, alcohol, drug abuse, psychiatric, HIV/AIDS - Records containing any of this information requires signature from patient age 10 and older to sign for release of records

Signature of Patient or Legal Representative:	Date:
Printed name of Patient of Legal Representative:	Relationship to Patient: